November 2014 - Monthly Provider Support Call Summary

Please share with your case managers and administrative staff or other employees.

Each month the WDH-Behavioral Health Division holds a monthly provider support call to let providers know what is going on and give additional clarification on items that have been released. **The next call is Monday, January 26th at 2pm**. **There will not be a call in December due to the holidays.**

CALL TOPICS & SUMMARY

Reporting Address Changes (Phillip)

- We would like to remind all providers of the process for reporting a change in address, phone number or email address
- Providers shall report any changes in their mailing or physical address, phone number and/or email address to their local Provider Support Specialist by email or fax. These changes should not be sent to Xerox. The Provider Support Specialist will inform Xerox of these changes in accordance with established procedures agreed upon between Xerox and the Division
- If address changes are not reported and mail is returned then this could lead to payments being suspended and you would also not receive your 1099 at the end of the year.
- We would also like to remind providers of the requirements outlined in Chapter 45 sections 23 and 24 when changing service locations or opening a new service location. The provider shall notify the Division of the new location at least 30 calendar days before the location is to be used to provide services. The provider shall not provide services in the new location until the Division has reviewed the external inspection report and has verified that all recommendations have been addressed. The Division shall complete an on –site visit of the new location within 6 months.

HCB Setting Transition plan update

Please go to http://health.wyo.gov/ddd to view the latest draft of the state's HCB Transition plan! The ABI waiver plan, ALF plan, and Statewide Plan have been submitted to CMS.

- Public comments overwhelmingly recommended that the Division focus on assuring services are supporting people to be integrated in the community instead of focusing on the location where services are delivered.
- Because of this emphasis, the division removed some flags from the provider setting analysis. The industrial park and zoning flags for settings were eliminated.
- The settings were evaluated for distance from other residences or businesses, but the distance will not be used to disqualify a setting from being considered HCB.
- Settings that are adjacent to other providers providing disability specific services will not disqualify a setting from being considered HCB.
- The non-residential settings that appear to segregate people with disabilities from the general public will not be disqualified from being considered HCB on this fact alone; the setting will be evaluated for other characteristics and individual experiences before being considered non-HCB.
- Rather than requiring specific milestones each year, providers will be issued a report of areas of non-compliance and will complete a transition plan with milestones and timelines each year.
- They will have the rest of the five years to come into compliance with the standards but must make progress each year. State monitoring processes will oversee the provider's compliance to their own transition plans.
- 333 Settings were evaluated for the ABI and DD populations, 12 are in compliance and the rest are not YET in compliance, but with modifications they should be in compliance at the end of five year transition timeline. We are finding that some providers did not take the survey so more settings will be evaluated as they are found.

- Further analysis of the settings through stakeholder surveys, onsite visits, case management reports, and participant and guardian interviews will be conducted during 2015 and 2016 to ensure that any setting with areas of non-compliance will be addressed by providers. No settings have been determined at this time to be non-HCB at this time and subject to heightened scrutiny by CMS.
- Any provider found out of compliance with an HCB standard in any setting must develop and implement a transition plan to make changes in order to meet the standards. The provider must ensure the policies and practices of their organization are changed where appropriate and that board members, staff, participants and guardians are aware of the systemic changes. Providers will be able to uniquely adjust or restructure their business to meet the standards within the four years left in the transition plan, but must report annual progress on milestones.
- Plan of care will be modified to cover more information in the new rules and the requirements for rights restrictions. Please review the timelines in the ABI transition plan posted, since all BHD waivers will follow the same plan. The statewide transition plan will be posted soon as well.

Case management unit change

- A bulletin went out on Friday making an announcement about the change from the monthly case management unit to the 15 minute.
- In response to significant public input on the change to a 15 minute case management unit, the Division has made the decision to continue to offer the opportunity for case managers to use the monthly case management unit until the waiver service rates can be rebased and approved by the legislature. Working with the participant, guardian and the participant's team, case managers can decide to use either the 15 minute unit or monthly unit.
- A new rate, cost and time study on case management should be conducted to establish a current rate reimbursement methodology and study the options available for unit types. As the contractor for this project is procured, the Division will issue a request to case managers to take part in the study.
- Since many plans of care have the 15 minute unit due to start in January, and some case managers are already using it, the Division will implement a transition process to get the plans modified.
- The Division will use a transition process by plan of care start dates to get the plans modified within the next three (3) months. We are asking that case managers follow the timeline below. Standard procedures must be followed including a new signature page with current dates must be signed and uploaded with each modification. Modifications must have a first of the month start date.
- **Any modifications submitted outside of this timeline are being rolled back by Division staff. We need to stick to this timeline to get all plan approvals and transitions completed timely.**

Modification Submission Timeline

Plan of care start dates	Due date to Submit Modifications back to a monthly unit
January	Submit change when plan is submitted by Dec 1.
February, March, April, May	December 10, 2014
June, July, August	January 15, 2015
September, October, November, December	February 15, 2015

**You may submit modifications after these dates to switch unit types as well.*

Case Management Documentation requirements

- The expectation of case management documentation is to record all billable activities conducted on a participant's behalf on a monthly basis, regardless of how many hours are provided. The case file on a participant must be able to stand alone in the case of a transition to a new provider.
- The documentation standards will be clarified in the case management guide. The forms will not be revised at this time.

- We will hold a webinar to train case managers on how to better document notes for a person's case file according to Division standards.
- During the rate rebasement process, the documentation of the case management billable services will be closely monitored and studied so it will be important to have comprehensive notes for all billable activities performed each month, regardless of the 2 hour minimum.

Monthly Support call notes are posted to our website:
http://health.wyo.gov/ddd/ComprehensiveandSupportsWaiver.html

Thank you for reading and for making time to call in each month!